

CHAPTER 3

Developing a Control Profile: Assessing the Theory

WHAT MIGHT the therapist have said to have elicited the patient response "All circumstances are beyond my control"? And what might the client initially have said? We might imagine the following:

PATIENT: I feel totally out of control in my life.

THERAPIST: (*Empathetic, then followed by a directive, pinpointing, clarifying strategy*) That sounds like it must be quite painful. Can you be a bit more specific. What circumstances in particular seem out of control?

PATIENT: All. . . .

We see here the client's need for a sense of control, which presumably brought him into therapy. The therapist then attempted to clarify general domain versus domain-specific areas of loss of control. We can see the difficulty, at least for some clients, in differentiating general domain and domain-specific issues: Sometimes loss of control in one area seems to overwhelm all aspects of a person's life.

What occurs in this dialogue is an informal effort to develop a "control profile" of the patient. In this chapter we present our more formal efforts to assess an individual's psychological control profile through the development of a standardized assessment inventory, the Shapiro Control Inventory (SCI; Shapiro 1994a). The SCI is based on the theory presented in Chapter 2 and measures the four central components of control:

1. *Sense of control*: Whether the individual believes his current life situation is in control, and to what extent he believes he has the skills and competence to gain and maintain a sense of control.

2. *Modes of control*: The characteristic cognitive and behavioral styles for obtaining and maintaining control, reflecting coping styles of positive assertive, positive yielding, negative assertive, and negative yielding.
3. *Motivation for control*: Whether a person has a low or high desire for control and the areas where she wants to gain more control and where she fears losing control.
4. *Agency of control*: The source of a person's sense of control. Does the person gain a sense of control from self-efforts, the efforts of others, or both?

The SCI provides the clinician with a systematic summary of the patient's specific control-related problem, what mode of control the patient wishes to use to address the problem, and where there are specific control deficit(s) that need to be focused on.

The first part of this chapter provides an overview of the SCI. The second part of the chapter offers examples of control profiles from patients with concerns related to physical health (cardiovascular risk) and mental health (depression, generalized anxiety). The final part of the chapter provides more in-depth suggestions for the use of the assessment material.

MEASURING CONTROL

The literature shows that a person's believing that he has control can often be as important as actually having behavioral control (Bandura, 1977; Glass & Singer, 1973; Lefcourt, 1973; Taylor & Brown, 1988). Therefore, it is critical to investigate a person's sense of control as a state of consciousness, that is, a person's self-perceptions regarding control, summarized in a self-report control profile.

Over the past three decades, efforts to measure the increased complexity of perceived human control have moved from general domain to specific domains and from human control as a unitary construct to human control as a multifaceted molar construct (Rotter, 1966; Shapiro, 1994; Wallston et al., 1978). Greater definitional and conceptual precision is now needed to reflect this increased understanding (Hinson, 1988; Imada & Imada, 1988; Logue, 1988; Rodin, 1990; Syme, 1989).

The first-generation measurement of control was Julian Rotter's Internal External Locus of Control Scale in the 1960s (Rotter, 1966). This scale involved 29 questions: 23 of which were relevant, and 6 of which were fillers. The relevant questions assessed, in a forced-choice manner, whether individuals believed that an area was under their internal control, or whether control came from external circumstances. For example, a person taking the test would need to choose between the following statements in item 5:

- a. The idea that teachers are unfair to students is nonsense.
- b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

Choosing *a* would be a point for internal locus of control. The test provided one overall general-domain score reflecting whether a person had a more internal or more external control orientation.

A second-generation test was developed in the 1970s by Wallston et al. Their test was domain specific—related to health—rather than general domain, like Rotter's. Further, based on research of Levenson et al. (1974, 1981), the Wallston et al. test did not make internal/external an either/or proposition, but allowed for scores reflecting three different agents of control:

- Internal locus of control regarding health: "If I take care of myself, I can avoid illness."
- External, powerful-other, positive locus of control regarding health: "Having regular contact with my physician is the best way for me to avoid illness."
- A chance dimension: "Most things that affect my health happen to me by accident."

The locus of control scales by Rotter and Wallston have made major contributions to our understanding of control. In the following section we point out some of the additional refinements we have made in our development of a third-generation inventory, the SCI.

THE SHAPIRO CONTROL INVENTORY

Over the past 20 years we have developed and tested the SCI, a paper-and-pencil self-assessment inventory consisting of 187 items. Its intent is to serve as a reliable and valid control inventory for the clinician to utilize with patients in both clinical and health care settings; it takes approximately 20 minutes to administer.

Following the advice of Hayes (Hayes, Nelson, & Jarrett, 1987), we have sought to make the individual specific control profile measured by the SCI both multidimensional and clinically relevant. Further, we have also followed Matarazzo's (1992) suggestion that investigators of psychological theories and constructs should seek to determine neurobiological correlates. Our research (Shapiro, Wu, et al., 1995) has begun to link control constructs of sense of control and modes of control with brain regions—functional neuroanatomy—through positron emission tomography.

The development of the SCI has involved several thousand individuals, ranging in age from 13 to 91, throughout all regions in the United States.

Some had physical health problems such as cancer or heart disease or were at cardiovascular risk; some had Diagnostic and Statistical Manual (*DSM*) disorders, including panic attack, generalized anxiety, depression, borderline personality disorders, and restricted eating disorders; and an at-risk group, adult children of alcoholics. The inventory has now been translated into several languages, and research with clinical populations in other countries (Japan, China, Spain, Israel, New Zealand, Germany) is ongoing.

Comparisons have been undertaken with both standard psychiatric tests such as the Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway & McKinley, 1943; Butcher, et al., 1990, 1992; Gottschalk, et al., 1997) and control tests such as Rotter's Internal External Locus of Control Scale (IELCS; 1966) and the Multidimensional Health Locus of Control Scales (MHLCS) of Wallston et al. (1978). Over a dozen reliability and validity studies were conducted (summarized in Shapiro, 1994) with clinical and normative populations. Here we present the main aspects of the SCI control profile, detail their relevance to clinicians, and summarize the important findings.

There are important advantages to a systematic, structured, quantitative assessment approach such as that of the SCI. It provides a standardized, objective way to assess a person's control profile in a relatively brief time. Further, such quantitative assessment can be fleshed out and further information sought through the use of qualitative understanding of what we call a patient's *control story*. A further elaboration of the control story, a narrative detailing a person's prior parental experiences, salient control-related life events, and current assumptions about control can be found in Chapter 9.

MEASURING THE FOUR KEY COMPONENTS OF CONTROL

Four components of our control theory are measured by the SCI: sense of control, modes, motivation, and agency. Despite its conceptual complexity, the SCI has a simple format that facilitates patient self-administration. Further, it is available on scannable forms that can be computer scored, providing the health care professional a printout showing a patient's control profile. (A sample copy is provided in Appendix A.)

SENSE OF CONTROL IN THE GENERAL DOMAIN AND SPECIFIC DOMAIN

The SCI measures sense of control in both the general domain (trait) and in a domain-specific manner (state). Neither the Rotter (1966) nor the Wallston et al. (1978) tests of control indicated whether the subject felt a "sense of

control." Further, whereas Rotter's test was general domain, the Wallston test was domain specific only for health. It is now clear that measuring sense of control requires information regarding a person's general-domain beliefs that he or she has control and can gain control if desired, as well as domain-specific control beliefs across multiple parameters. The SCI measures both.

General Domain Sense of Control

The SCI measures general-domain sense of control through a positive sense of control scale, a negative sense of control scale, and an overall general-domain sense of control scale formed from combining the positive and negative scales:

- The overall sense of control scale (Scale 1) provides a score based on the individual's responses to all of the SCI's general-domain sense-of-control items. It gives the clinician the broadest view of the subject's sense of control.
- The negative sense of control scale measures whether the patient feels that he or she is losing control in areas where he or she once had it (Brehm, 1966), lacks self-control, lacks control of the environment (other people and situations), feels too passive and helpless (Seligman, 1975), and is controlled too much by other individuals.
- A positive sense of control scale assesses current sense of positive control: the patient's belief in his or her ability to attain control in the future if he or she so wishes (Bandura's self-efficacy), ability to utilize the two positive modes of attaining control, and current level of self-control. It also includes the six dimensions of positive control determined by previous research: *awareness* of feelings and motivations; ability to make *choices* about the important things in life; ability to set meaningful *goals*; willingness to take *responsibility* for that which is controllable; *skills* to carry out the goals; and motivation and *determination* to follow through (Shapiro 1983a).

Domain Specific

Rotter's scale is only general domain. However, research has shown the importance and higher validity of domain-specific data (Steptoe & Appels, 1989; Wallston, 1989). Therefore, subsequent efforts in control assessment have been primarily domain specific, such as the MHLCs, and even disease specific (e.g., cancer, diabetes, pain). There have also been efforts to measure the role of control in domains such as interpersonal relations (Schutz, 1958), career (Parkes, 1989), family (Moos & Moos, 1994), and beliefs about the nature of the universe (Kass et al., 1991).

However, there are limitations to using single-domain scales. Thompson et al. (1988) and Burger (1989) stated that control can have multidimensional

TABLE 3.1
SCI PARAMETERS WITHIN DOMAINS

Domains	Parameters
Body	Eating behavior, physical exercise, way body functions, general physical appearance, weight, and sexuality
Mind	Thoughts and attention, stress and sadness
Interpersonal Relations	Friends, significant other, children, and family of origin
Career	Employment situation, work habits, and spending habits
Self	Self-esteem and time management
Environment	Place where person lives
Impulse Control	Drug and alcohol consumption, smoking, violent behavior, and gambling

effects, and successfully gaining control in one area may be offset by loss of control (or fear of loss of control) in another. Further, without multiple-domain assessment, it is impossible to determine to what extent loss of control in one area generalizes to other areas. Therefore, measurement of control in both general and specific domains is important (Broenen & Donk, 1992).

The SCI has a domain-specific scale (Scale 4) consisting of 25 items relating to specific domains that the literature has emphasized as important areas of control (see Table 3.1).

Respondents state whether a particular area of their life is perceived to be in or out of control. The domain-specific items are scored overall, combining all 25 items into one domain-specific scale. However, they may also be examined individually, and, in this way, it is possible to determine whether a person feels in control in one area (e.g., work environment), but not in another (e.g., the interpersonal arena).

Further, it is possible to determine whether there is overlap between a person's overall sense of control in the specific domains and the general domain. A person's situation-specific (Mischel, 1968, 1979, 1984) and parameter-specific appraisal may not always be congruent with the individual's general-domain global appraisal. When this lack of congruence occurs, it and the reasons for the investigation can be pointed out to the client.

FOUR MODES OF CONTROL

As discussed in Chapter 2, it has been argued that the primary emphasis on assertive, instrumental change strategies to effect a sense of control may be

both culture bound and limiting (Shapiro, Evans, & Shapiro, 1987). As noted, most of the Western psychological research on control has focused on having control through an active, altering mode of control. We have suggested that this mode can be understood as part of a larger four-quadrant model (see Figure 2.1, p. 23). Generally, in the Western psychological literature, a contrast is made between individuals who have this assertive, decisive, instrumental mode (Quadrant 1—positive assertive) and people who are more timid, passive, and helpless, having too little control (Quadrant 4—negative yielding [Burger, Cooper 1979]). However, there are times when active personal control is inappropriate or excessive, leading to overcontrol (Quadrant 3); and there is a positive yielding mode of control (Quadrant 2) that needs to be included in our assessment of healthy coping.

The lack of an inventory to measure these modes was one of the initial motivations behind developing the SCI (Shapiro 1982, 1983b; Shapiro & Bates, 1990; Shapiro & Zifferblatt, 1976b). Therefore, the SCI is designed to measure both assertive and accepting modes of control. It also has scales to measure overcontrol (negative assertive mode) and too little control (negative yielding mode), thereby providing four different modes of control scales (Scales 5–8). Positive psychological health is considered to occur when individuals have high scores in both a positive yielding and positive assertive mode of control, and low scores on a negative assertive (overcontrol) and negative yielding modes of control (Shapiro, 1978, 1982, 1985, 1994a).

Quadrant 1: Positive Assertive

Quadrant 1 measures an individual's self-description in terms of the ability to use an active, altering mode of control to change the environment, others, and oneself, and instrumental activity in a positive way toward the accomplishment of some goal or task. It includes descriptive words and phrases such as *decisive*, *communicating needs*, and *leading*. For example, if a person is concerned about weight and decides to begin an exercise and diet program, that person is using an active, altering mode to attempt to control physical appearance and lifestyle (for example, "I have currently begun an exercise program to get in better shape").

Quadrant 2: Positive Yielding/Acceptance

Quadrant 2 involves knowing when a sense of control needs to come from letting go of active control. Its descriptive words include *patient*, *trusting*, and *accepting*. For example, if a person concerned about being overweight decides to accept that condition in a positive manner, he or she is using a yielding, accepting mode of control (for example, "I am comfortable with how I look and do not feel any need to lose weight").

Quadrant 3: Negative Assertive

Quadrant 3 involves too much active control, and its descriptive words include *manipulating*, *overcontrolling*, and *dogmatic*. For example, the overweight person who tries too hard to lose weight very quickly, constantly weighing and monitoring every aspect of food intake is evincing a Quadrant 3, negative assertive, mode of control (for example, "If I can't lose these extra 2 pounds, I will never be happy with myself. I must change how I look").

Quadrant 4: Negative Yielding

Quadrant 4 involves too little control, and its descriptive words include *indecisive*, *manipulated*, and *timid*. For example, the person who feels stuck being overweight, but feels helpless and unable to change, would be an example of the Quadrant 4 negative yielding mode of control (for example, "I feel out of control of my body, but I know it will not do any good to try to lose weight because I will just fail again").

MOTIVATION FOR CONTROL

Neither the IELCS nor the MHLCS involve a motivational variable of desire or effort for control. Desire for control has been distinguished from locus of control (Burger & Cooper, 1979, 1985). Wallston (1992), commenting on the failure of the MHLCS to predict health outcomes, suggested that it only measured half the theory—it measured expectancy beliefs, but not whether engaging in such behaviors was desirable or reinforcing. Thus, the SCI addresses control-related motivational factors in the subject's life.

The SCI contains a desire-for-control scale (Scale 9), which measures an individual's motivation to attain and maintain control, both over oneself and over others and the environment. It includes the fear of losing control, importance of seeming in control, efforts to establish control, and needs for achievement and power (McClelland, 1961, 1975), control as order and predictability (Kelly, 1955), and control and awareness style (e.g., sensitizer/repressor) in terms of information seeking for problem solving (Schwartz, 1983).

Motivation for control is measured not only by the desire-for-control scale, but also by the following:

1. *Issues of overcontrol*: When persons feel they are exerting too much control (e.g., aggressive, overcontrolling) or too much self-control (e.g., holding in anger even when they would like to express it).
2. *Satisfaction with modes*: Persons note whether they are satisfied with modes, and where not satisfied, which modes they wish to increase or decrease.

3. *Parameter satisfaction level*: This measure examines satisfaction with the 25 parameters and which parameters are of concern to the individual.
4. *Parameters of concern and preferred response style*: For those parameters which are a concern, subjects are asked whether their preferred mode of control for addressing the concern is an alter/change strategy or a yielding/accepting mode of control strategy.

AGENCY OF CONTROL: SELF OR OTHER

The locus, or source, of a person's sense of control, first researched by the scales developed by Rotter's and Wallston, continues to be clinically important. The source of control is referred to as the *agent of control*, and that which is controlled is referred to as the *object of control*.

The SCI incorporates questions assessing a person's belief regarding agency of control. Specifically, it measures the source from which a person gains a sense of control by asking in a non-mutually exclusive way to what extent sense of control comes from one's own effort, and also whether others help one make changes so that one can gain more control over one's life. Others as a source of control is then refined: whether from family and friends, government and society, and/or a higher power (god/God, religion, spiritual beliefs).

AN EXAMPLE OF SCI CONTROL PROFILES

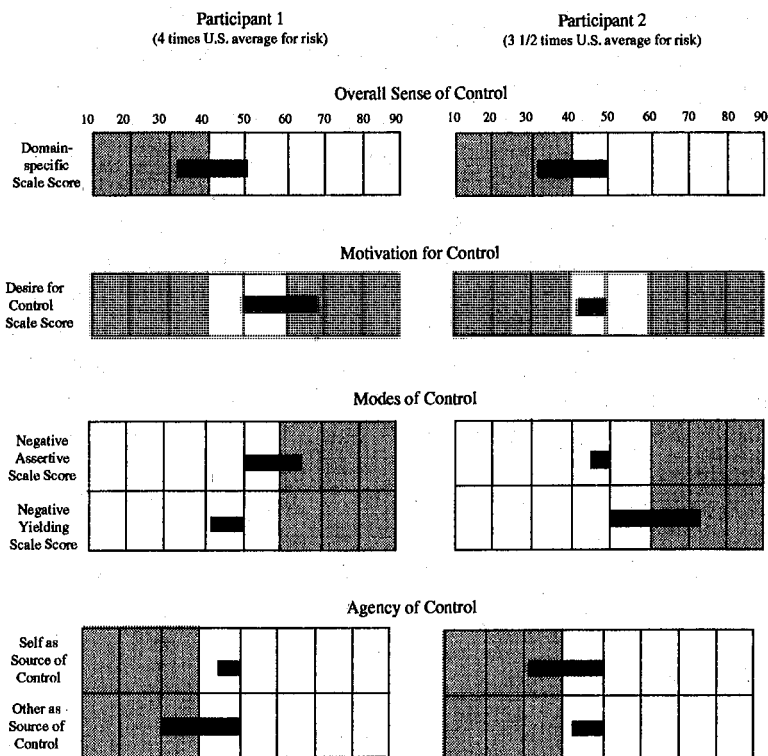
In this section we present control profiles taken from our clinical research. We begin with a study related to cardiovascular risk, and then examine control profiles of individuals suffering from depression and generalized anxiety.

PHYSICAL HEALTH

Control as a psychosocial variable has been associated with cardiovascular risk, but the data are conflicting and often contradictory. In one set of findings, low perceived control is associated with cardiovascular risk (Bugental et al., 1993; Karasek et al., 1982; Schnall et al., 1990; Wright, 1992). In a second set, higher perceived control is associated with cardiovascular risk (Seeman, 1991). In a third set, the motivational variable of desire for control, fear of loss of control, and efforts for control is associated with cardiovascular risk (Brown & Smith, 1992; Dembroski et al., 1984; Glass, 1977).

The multidimensional control profile of the SCI clarifies some of these seemingly contradictory findings. A recent study using the SCI identified two different profiles associated with high cardiovascular risk (Shapiro, Lindberg, Daniels, Breuer, & Astin, 1994). Cardiovascular risk was determined by serum glucose level, left ventricular hypertrophy, serum cholesterol level, HDL level, and systolic blood pressure, after adjusting for age and gender. As can be seen from Figure 3.1, both patient 1 (with cardiovascular risk 4 times the U.S. average) and patient 2 (with cardiovascular risk 3.5 times the U.S. average) have low domain-specific sense of control scores (represented by the black bar entering the gray area).

However, from this point, their control profiles differ markedly from one another. Patient 1's profile shows an elevated score on both the desire for control scale and the negative assertive "overcontrolling" scale. Further, he shows a low score on the agency dimension others as a positive source of control (i.e., an unwillingness to rely on or trust others for help in gaining a sense of control).



Note. All scores are standardized with a mean of 50, and each 10-point increment represents 1 standard deviation. The solid black bars represent the participants' scores on each control dimension, and any bar falling in the gray shaded area represents a control score of at least 1 standard deviation in a nonpsychologically healthy direction.

FIGURE 3.1
CONTROL PROFILE OF TWO PATIENTS AT HIGH CARDIOVASCULAR RISK

Patient 2, by contrast, has a normal desire for control score, but an elevated score on the negative yielding scale (too little control) and a low score on self as a positive source of control.

The profile of these two patients suggests that different control profiles can be associated with higher cardiovascular risk. Therefore, different control-related therapeutic interventions would be needed, depending on the person's control profile. For example, as discussed in Part Three, individual-specific matching of control-related interventions involves teaching patient 1 ways to decrease negative assertive overcontrol, decrease desire for control, and increase the ability to gain a sense of control from others through techniques such as meditation and relaxation training. The intervention for patient 2 would involve decreasing feelings of negative yielding (helplessness and too little control) and increasing feelings of agency of control from self through techniques such as assertiveness and self-efficacy training.

Several studies have successfully utilized forms of this matching approach between control personality variables and individual differences with a particular control-enhancing intervention (Bugental, Whalen, & Henckert, 1977; Burish et al., 1984; Nowlis & Edgar, 1987; Reich & Zautra, 1990; Schwartz, 1983; Shapiro, 1990). Matching needs to take into consideration how gender and gender roles influence the nature of control concerns, as well as the goals for and strategies of control (Shapiro & Shapiro, 1983). Flexible coping is possible only when an individual has the skills of both modes of control and can use them either in an integrated way or differentially, depending on the exigencies of the circumstances. Further, matching may require teaching patients coping flexibility (Schwartz, & Rogers, 1994) so that different modes of control can be used at different points in treatment (Heim et al., 1987, 1992, 1997); in different person/situation interactions (Kenrick & Funder, 1988; Mischel, 1968, 1979); and during various developmental phases (Heath, 1983; Levinson, 1978; Vaillant, 1977; Weisz, 1990). Finally, gaining control through assertive/change and yielding/accepting modes are not mutually exclusive. For example, both positive assertiveness and positive yielding increased as a result of a 2-year cognitive/behavioral intervention with Type A individuals who had each experienced one myocardial infarction (Shapiro, Friedman, & Piaget, 1991).

MENTAL HEALTH CONTROL PROFILES

In several different studies control profiles have been developed on *DSM* populations, including those with eating disorders (Shapiro, Blinder et al., 1993); depression, generalized anxiety, borderline, and panic attack (Shapiro, Potkin et al., 1993); and the at-risk population adult children of alcoholics (Shapiro, Weatherferd & Kaufman, 1994). An overall comparison of

the general-domain sense of control scores (Scale 1) for these populations is provided in Figure 3.2.

This figure provides an overall comparison of the sense of control domain for different populations. However, for the clinician, what is of particular importance is a more refined analysis of differences in control profiles among clinical populations. In the following paragraphs we examine SCI control profiles of two specific populations: persons with depression and persons with anxiety.

Several different theories are germane to depression and control. Beck and colleagues (1976, 1985, 1989) argue for the importance of an increase in mastery events and cognitions of mastery. Some have argued that depressed individuals lack skills to elicit positive reinforcement from others (Lewinsohn's 1974 response-contingent positive reinforcement; Matthews self-control, 1977; Seligman's learned helplessness as lack of control, 1975; Abramson, Garber, & Seligman, 1980). Control is also considered an important variable in anxiety disorders (Bandura, 1988; Barlow, 1988; Beck & Emery, 1985; Shapiro, 1990). For example, Barlow (1988) defined anxiety as a fragmented cognitive/affective process in which individuals have a sense of unpredictability or lack of control over potentially negative or harmful life events.

Kabat-Zinn (1990), director of the Stress Reduction Clinic at the University of Massachusetts, Worcester, summarized in lay terms what many clinicians and researchers might consider some of the defining characteristics of depression and anxiety: "The issue of control is central to coping with problems with stress" (p. 3). When we feel overwhelmed by pressures of life and see our efforts as ineffectual, we can end up feeling depressed and help-

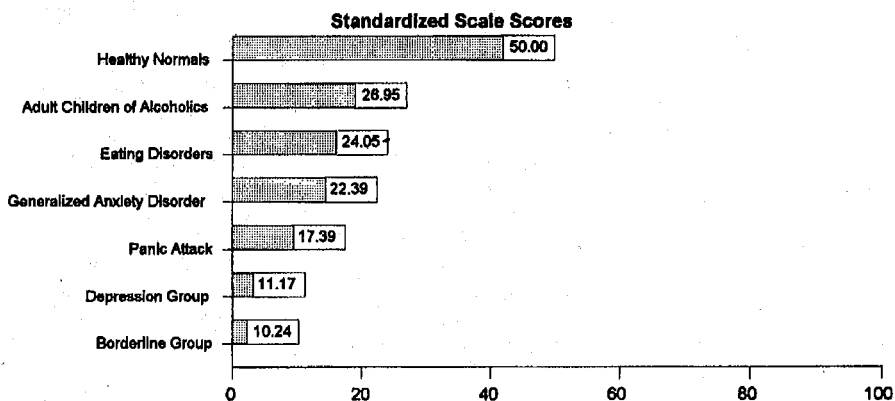


FIGURE 3.2
OVERALL SENSE OF CONTROL, GENERAL DOMAIN, SCALE 1,
STANDARDIZED SCALE SCORES

TABLE 3.2

COMPARISON OF CONTROL PROFILES OF DEPRESSION AND GENERALIZED ANXIETY

	Depression Group	Generalized Anxiety Disorder Group
MODE OF CONTROL		
Quadrant One Positive Assertive	Lowest Score†	Highest Score*
Quadrant Two Positive Yielding (overacts)	—	Lowest Score: I am able to calmly accept that which I am not able to change or alter†
Quadrant Three Negative Assertive	—	Highest Score†
Quadrant Four Negative Yielding	Highest Score: "I am too passive and helpless."†	
AGENCY OF CONTROL	Lowest Score on positive agency from self.† Lowest Score on positive agency from other† Most external locus of control scale.† Highest Score: "I hold my anger in even when I want to express it"†	
SENSE OF CONTROL	Lowest positive sense of control scale† Lowest perceived self-efficacy† Lowest on following dimensions: Ability to set clear, realistic, and meaningful goals† Ability to take appropriate responsibility for that over which one has control† "I make the appropriate amount of effort and have sufficient discipline to reach my goals"†	Highest Score on: * Perceived self-control* Overall general domain sense of control scale* The positive sense of control scale* Being in control on several specific parameters (eating, physical exercise, body weight, sexuality, control of thought, relationship with significant other, way I feel about self, spending habits, alcohol consumption, and smoking)
Domain Specific	Felt least "in control" in the areas of physical appearance, eating behavior, physical exercise, body weight, control of thoughts, employment situation, work habits, and smoking and drug usage†	Lowest Score on: Being "in control" on domain items on way my body functions, attention, concentration, and stress†
DESIRE FOR CONTROL	Lowest fear of losing control*	

* = Positive aspect of control profile

† = Problematic aspect of profile

less. "Nothing will seem controllable or even worth trying to control" (p. 4). Conversely, when the world seems threatening, but only potentially overwhelming, feelings of insecurity rather than depression may predominate, causing us to "worry incessantly about all the things [we] think threaten or might threaten [our] sense of control" (p. 4).

In the following we summarize some of the findings related to our investigation of individuals suffering from depression and anxiety, as part of a study that compared panic attack, borderline, depressed, and generalized-anxiety patients. The Depressed and Generalized Anxiety Profiles are summarized in Table 3.2.

As can be seen from Table 3.2, the depressed group had, as expected, the lowest positive assertive score and the highest negative yielding score as well as the lowest perceived self-efficacy score. The generalized anxiety group, on the other hand, had the highest positive assertive score, but also the highest negative assertive, overcontrolling score; felt they had too much self-control; and had the lowest score on the ability to calmly accept things over which they had no control. These findings are consistent with what expected based on previous theories of control, and they provide the clinician with an overview summary of salient control-related issues that need to be addressed in therapy.

WAYS FOR THE CLINICIAN TO USE THIS ASSESSMENT MATERIAL

An example of the graphic printout of an SCI control profile is illustrated in Figure 3.1 with cardiovascular patients. Further, as can be seen in Table 3.2, broad-scale summary information can also be complemented by more detailed within and between scale analysis.

For example, knowing that a client has a low general-domain positive sense of control or a low overall domain-specific sense of control is important. But in order to help answer the clinical question posed earlier in this chapter, we then need to proceed to a finer-grained, more precise level of analysis. We would want to know what are the general-domain dimensions that might be contributing to the low positive sense of control; what are the specific domain parameters that are most out of control; and which mode(s) the client would like to use to address the concern(s).

As the sophisticated clinician knows, psychotherapy is both an art and a science. Part of the task of the clinician is to bring together the different pieces of information and shape them into a whole, while not losing sight of the details. The same needs to be done with the SCI's nine scales, additional refinements, and item-level analysis.

Following are some general suggestions and guidelines that have proved helpful in past research and clinical work with the SCI.

THE PERSON'S CURRENT SENSE OF CONTROL STATUS

One of the first and most important issues to determine is the client's overall sense of control status. This information is provided in scale 1, the overall general-domain sense of control scale, and scale 4, the overall domain-specific sense of control scale. This information is important, first from a health standpoint. As detailed in Chapter 6, the psychological construct sense of control affects physical health status, including morbidity and mortality. Sense of control as an independent variable can be a protective buffer against severity of subsequent health-related concerns. Second, a comparison of a person's overall general domain sense of control can be compared to the person's overall domain-specific sense of control. Generally, these should overlap. However, as noted, a person's situation-specific (Mischel, 1968, 1979, 1984), and parameter-specific appraisal may not always be congruent with the individual's general-domain global appraisal. When this lack of congruence occurs, it can be pointed out to the client, and the reasons for this lack of congruence.

FACTORS RELATED TO SENSE OF CONTROL STATUS

Four factors need to be investigated regarding sense of control status: agency, modes, dimensions, and parameters.

Agency of Control

As noted, agency of control refers to how much of a person's sense of control comes from self-efforts and how much of the sense of control comes from (non-mutually exclusive) others' efforts. The clinician should be concerned when agency for control from both self and others is below that of the psychologically healthy comparison group.

Also worth investigating is when sense of control from self is consistent with a healthy normal group, but sense of control from others is below normal (for example, patient 1 in Figure 3.1). Although this may be a healthy profile, it is possible that the client has too high a need for self-reliance and autonomy, and has too low an expectancy of help from others.

Conversely, if sense of control from others is consistent with healthy normals, but sense of control from self is low, this too should be investigated (for example, patient 2 in Figure 3.1). There may be too much of a feeling of reliance on others, to the exclusion of one's own efforts. Again, this specific configuration is not necessarily a problem (there may be a feeling of healthy interconnectedness or control by a higher power or religious beliefs) but should at least be explored by the clinician.

Modes

The modes of control scales (5 to 8) provide general domain information about whether and to what extent the person feels he or she has these characteristic cognitive or behavioral styles of responding to control-related issues. A pretherapy profile can note whether there is imbalance in the modes that needs to be addressed. A healthy profile is one in which the positive assertive and positive yielding quadrants are equal to or higher than those of the psychologically healthy comparison group, and negative assertive and negative yielding quadrants are equal to or lower than those of the psychologically healthy comparison group.

An important part of a control-based approach to psychotherapy and health care is to help clients learn to understand and select appropriate modes of control strategies based on differentiating and clarifying which aspects of their concerns are under their control and which are not. The client can be helped to understand that psychologically healthy individuals favor and use both positive assertive and positive yielding strategies. The two positive control modes are not exclusionary choices, but may be appropriate at different times and in different situations in a person's life. This understanding may broaden the client's repertoire of coping styles.

The clinician should reinforce the client for modes that are similar to those of the psychologically healthy normal comparison group and focus on the client's understanding of those modes that are being nonadaptively used. This may involve increasing the positive assertive or positive yielding modes and decreasing the use of the negative assertive or negative yielding modes.

Dimensions: Item-Level Analysis

Further information on a person's sense of control status can come from item-level analysis of scales 2 and 3 (positive and negative sense of control). For example, in the positive sense of control scale, we can examine the six dimensions related to control: ability to choose, goal-setting, responsibility, awareness of feelings, appropriate effort and discipline, and skills and abilities (Shapiro, 1983a). This information can be clinically useful in helping the therapist determine where the specific control deficits exist that need to be focused on, and more clearly tailoring control-related strategies to those areas, as we discuss in Part Three.

In scale 3, negative sense of control and item analysis can provide information regarding whether the patient feels that he or she tends to lose control, is too passive and helpless, lets others have too much control over him or her, or is losing control in areas where he or she once had control.

Parameters Not in Control

What parameters are not in control is determined by doing an item analysis of scale 4, the overall domain-specific sense of control scale. Thus, it can be

determined in which of the 25 parameters in the 7 domains a person feels in control (refer to Table 3.1).

MOTIVATION FOR CONTROL-RELATED CHANGE

Four aspects of the SCI relate to a person's motivation to change: the desire-for-control scale, the person's overall satisfaction with his or her current use of the assertive and yielding modes of control, the person's satisfaction with the amount of control he or she has in each of the 25 parameters, and, most importantly, which parameters are of concern and which mode(s) the person wants to use to address the concerns.

Desire for Control

General-domain information on desire for control can come from the desire-for-control scale (scale 9). Clinical interpretation of the desire for control scale is not linear. Rather, clinical problems can be reflected in scores that are greater than or less than those of the psychologically healthy normals. Scores greater than those of the normals involve a preoccupation with control. Scores lower than those of the normal group often reflect a lack of optimism about being able to exercise control. However, we have found that for certain individuals, a lower desire for control may reflect a person who is at peace with himself or herself and the world. Further refinement can come from item analysis of the desire for control scale, as well as the additional items related to desire to let go of control and issues of overcontrol.

Mode Satisfaction Level

Additional information also comes from investigating the person's satisfaction level with each of the four modes of control. Generally, when they are not satisfied, people want to increase their Quadrant 1 positive assertive and Quadrant 2 positive yielding modes, and to decrease their negative assertive and negative yielding modes. On the diagnostic report, if a person wants less of a Quadrant 1 or 2 item or more of a Quadrant 3 or Quadrant 4 item, this is noted as a red flag that the clinician should investigate further.

Parameter Satisfaction Level

Another measure of satisfaction level is the number of the 25 different parameters that the person says are not a concern. Most healthy individuals report at least a few of the parameters as being a concern. Parameters that are not a concern can be seen as a foundation of strength in the client that the therapist can point out and on which the client can begin to build.

Parameters of Concern by Mode of Choice

Finally, at the most precise level of analysis, the clinician can determine which parameters are a concern, and, of those parameters, which ones the person wants to gain more control over by an assertive, altering mode of control and which by a yielding, accepting mode of control. This information enables the clinician to determine the subject's mode flexibility in coping with different parameters of concern. Generally, psychological health requires a certain flexibility in addressing parameters of concern (Heim et al., 1992; Schwartz & Rogers, 1994).

The clinician should review with the client all the parameters of concern and the mode with which the client wants to address them. The clinician needs to determine whether the client's acceptance is wisdom or passivity and whether the client's intent to change suggests positive, active empowerment or overcontrolling efforts and desires. If the concern and mode seem appropriate, the clinician can then work with the client on specific mode-by-parameter interventions.

ASSESSING THERAPEUTIC CHANGE

The SCI can be used to assess therapeutic change before, during, and after treatment. Because research indicates that sense of control is related to normalcy and psychological health, and lack of control is related to pathology, it is possible to assess progress in therapeutic treatment regardless of the approach: psychodynamic, cognitive/behavioral, or humanistic/existential.

Several different aspects can be observed in the process of therapeutic progress. It can be determined whether the overall sense of control—both general domain and domain specific—changes. On a general-domain item level, the clinician can investigate whether specific targeted dimensions (e.g., goal-setting, skills, responsibility) were affected. On a specific-domain item level, the therapist can examine whether interventions directed in one area (e.g., eating) are successful, and further, whether such interventions are having an effect in other control-related parameters (e.g., interpersonal relationships, sense of self). It is also possible to examine whether changes on the domain-specific items are reflected in changes in overall domain sense of control (Donk & Broenen, 1992). Further, the therapist can monitor whether the modes of control move in a psychologically healthy direction, with Quadrants 1 and 2 increasing and Quadrants 3 and 4 decreasing; and whether overall, regardless of score, the person is more satisfied with his or her four quadrant modes. Finally, the therapist can assess what combination of agency involving self-effort and other effort is most helpful for that particular individual.

Thus, the SCI is a clinically reliable and valid multidimensional control assessment instrument that can help the clinician in diagnosis, case conceptualization, treatment planning, and therapy evaluation. In so doing, it provides a foundation for a control-based approach to psychotherapy and health care in two ways. First, it can differentiate between control profiles of various clinical populations. Second, by developing a more sophisticated way to measure an individual's control profile, it can help the clinician select interventions most suited to a particular client.

In using the SCI, several caveats are necessary. First, a paper-and-pencil test does not give the richness of idiographic control stories and narratives such as assumptions about personal control and responsibility brought into the therapy/health care session (Brickman et al., 1982; Globus, 1980; Knowles, 1977; Shapiro & Shapiro, 1979). Such stories can provide important additional information beyond a paper-and-pencil test; they are discussed in Chapter 9. Second, a paper-and-pencil test cannot substitute for clinical judgment on issues of defenses, illusion of control, and inappropriate beliefs. For example, a person who beats his spouse may record on the inventory that he has a positive sense of control and is using a positive assertive Quadrant I mode of control. Similarly, the control profiles of some adult children of alcoholics unrealistically claim that all aspects of their life are in control. These control strategies involve "lower level" means of gaining and maintaining a sense of control. But what represents "higher level" control modes? Such a determination depends on the clinician's operating assumptions of what constitutes psychological problems and a view of what psychological health looks like.